Personality Disorders

For many screens we have left out the word “personality.”

As of 11 Jan 2016

Challenge

Unlike, for example, neurocognitive disorders where there are hundreds of facts about which to develop questions, exam writers for personality disorders have fewer facts from which to choose, so they do not wonder far from the DSMs and the Borderline practice guideline, but some reaching of Sadock and Sadock or Tasman for important clinical issues.

Sources

1] DSM-IV/DSM-5 [There is no difference between the two as to Personality Disorders]

2] APA Practice Guideline on Borderline.

3] Kaplan & Sadock's Synopsis

4] Tasman & Mohr's Fundamentals of Psychiatry.

Q: Basic Personalities

The field of psychology speaks of five basic personality traits [“dimensions” might better stimulate the answer than “traits]. What are they? What five traits addresses the person’s personality?

Ans: Basic Personality Traits

1. Openness to new experiences
2. Conscientiousness
3. Extraversion
4. Agreeableness
5. Neuroticism

Q. Meaning of “Alloplastic”

Ans. Meaning of “Alloplastic”

Adapt by trying to alter the external environment rather than themselves.

[Different meaning in surgery.]

Q. Manifestation

P.D. manifest in what four psychological areas? Note we are talking about the breakdown of personality disorders, not personalities.

Ans. Manifest

1. Cognition
2. Affectivity
3. Interpersonal functions
4. Impulse control

Q: List DSM – IV/5
Ten Personality Disorders

Ans: List P.D. - 1

1. Antisocial
2. Avoidant
3. Borderline
4. Dependent
5. Histrionic

Ans: List P.D. - 2

6. Narcissistic
7. Obsessive-compulsive
8. Paranoid
9. Schizoid
10. Schizotypal

Also available to clinicians:

11. Other specified
12. Unspecified

Q. Clusters

Describe the three Personality Disorder clusters.

Ans. Cluster A

Odd, aloof.

1] Schizotypal

2] Schizoid

3] Paranoid

Ans. Cluster B.

Dramatic, impulsive, and erratic.

1] Antisocial

2] Borderline

3] Histrionic

4] Narcissistic

Ans. Cluster C

Anxious and fearful.

1] Avoidant

2] Dependent

3] Obsessive-compulsive.

Q. P. D. with Schizophrenia?

Q. Which Personality Disorder is most common in relatives of those with schizophrenia?

Ans. P.D. with Schizophrenia

Ans. Schizotypal

Q: Suicide rate in P.D.

Q. Highest suicide rates in people with P.D.?

Ans: Suicide rate in P.D.

Ans.

Borderline

If Borderline not a choice, then antisocial.

Q: Substance-related disorders

- Which personality disorder is most common in those also suffering from substance-related disorders?

Ans: Substance-related disorders

- A. DSM-IV lists two:
- 1] antisocial [probably the exam's correct answer]
- 2] borderline.

Q: Early sexual abuse

- Q. Early sexual abuse is associated with which personality disorder?

Ans: Early sexual abuse

Borderline.

- [While not likely to be a question, early sexual abuse is more likely to be associated with suicidal acts than early physical or early verbal abuse.]

Q: Defense Mechanism Antisocial P.D.

Q. What defense mechanism used in antisocial P.D.?

Ans: Defense Mechanism Antisocial

Ans. Acting out.

Q: Antisocial disorder – prognosis?

Ans: Antisocial P.D. Prognosis

Ans. Improves with age, especially better in fifth decade [if they live that long].

Q: Avoidant disorder - dx

- Q. DSM-IV criteria for avoidant disorder? Four or more of what seven signs?

Ans: Avoidant disorder – dx - 1

- Four or more:
- 1. Avoids interpersonal contact because of fear of rejection.
- 2. Avoids people unless certain of being liked
- 3. restrained intimate relationships because of fear of being shamed.
- 4. see next slide

Ans: Avoidant disorder – dx - 2

- continued
- 4. preoccupied with thoughts of being criticized in social situations.
- 5. inhibited in new interpersonal situations
- 6. views self as socially inept
- 7. reluctant to engage in new activities

Q: Social phobia – avoidant disorder

- Q. What is the difference between social phobia and avoidant disorder?

Ans: Social phobia & avoidant disorder

- Lots of overlap, and:
- 1. Social phobia, in comparison to avoidant disorder, less likely to pervade all activities
- 2. Social phobia less likely to be prominent since childhood.

Q: Borderline - dx

- Q. DSM criteria? Five or more of what nine signs?

Ans: Borderline – dx - 1

- Criteria, 5 or more of:
- 1. Recurrent suicidal attempts, threats, or gestures, or recurrent self-injuring.
- 2. Self-damaging impulsivities outside 1. supra
- 3. Inability to control anger
- 4. Instability of mood outside 1., 2., and 3. supra

Ans: Borderline – dx - 2

- 5. Unstable interpersonal relationships
- 6. Frantic efforts to avoid sense of abandonment.
- 7. Unstable self-image
- 8. Chronic feelings of emptiness
- 9. Transient stress-related paranoid ideation of severe dissociations

Q: Borderline P.D. Impulsive

Q. Meds for impulsivity in borderline P.D.?

Ans: Borderline P.D. Impulsive

Ans. SSRIs

Q: Parasuicidal

- Q. Proven treatment for parasuicidal behavior?

Ans: Parasuicidal

- Dialectical Behavioral Treatment [DBT] was initially developed for parasuicidal behavior and has controlled studies supporting that view.

Q: Traumatized borderlines

Q. Pts who were traumatized in childhood and later have borderline P.D. show what neurobiological findings?

Ans: Borderline and traumatized

Ans.

Hyper-reactive hypothalamic-pituitary-adrenal [HPA] axis leading to enhanced ACTH and cortisol response.

Gabbard: AJP. 2005. 162:648-655

Q: Mentalization

- Q. Mentalization is part of?

Ans: Mentalization

- 1. DBT
- 2. Here-and-now psychoanalytic approaches may also include mentalization. [“Bateman” would be the correct answer if his name is part of the exam answers.]

Q: Borderlines and amygdala

Q. The amygdala size in borderlines?

Ans: Borderlines and amygdala

Ans. Smaller.

Gabbard: AJP. 2005. 162:648-655

Q: Dependent disorder

- Q. DSM-IV criteria? Five or more of what eight signs?

Ans: Dependent disorder – dx - 1

- DSM-IV expects 5 or more of:
- 1. Needs a lot of reassurance from others to make decisions
- 2. Needs others to make major decisions.
- 3. Fears disagreeing with others.
- 4. Lacks self-confidence to address new projects
- 5. see next slide

Ans: Dependent – dx - 2

- [Answer continued from prior slide].
- 5. Goes to excessive lengths to please others – including tasks that are unpleasant.
- 6. Feels helpless when alone
- 7. When one relationship ends, desperate for another
- 8. Preoccupied with fears of being left to take care of himself or herself

Q: Obsessive-compulsive P.D. Defense mechanisms

Q. Name common defense mechanism seen in this Disorder?

Ans: Obsessive-compulsive P.D. Defense mechanism

Ans.

Intellectualization

Isolation of affect

Reaction formation

Gabbard: AJP. 2005, 162:648-655.

Q: Paranoid disorder.

- Q. Treatment?

Ans: Paranoid disorder.

- Treatment includes:
- 1. Avoid confrontation of paranoid beliefs.
- 2. Respect pt's autonomy while exploring implications, logic and reality of the suspicions.
- 3. Meds? See next slide.

Ans: Paranoid Disorder - meds

- No controlled studies on use of meds, but generally felt that pt will regard meds with suspicion that one is trying to destroy their ideas, so avoid unless you can be seen as treating their “anxiousness,” “dysphoria,” whatever – if present. Then prescribe the med that addressed that problem.

Q: Schizoaffective P.D. Relatives

Q. Schizoaffective P.D. patient's relatives are most likley to be?

Ans: Schizoaffective P.D. Relatives

Ans. Mood disorder, not schizophrenia.

Q: Schizoid P.D. Core Feature

Q. What is the core feature of schizoid personality disorder? List two.

Ans: Schizoid P.D.
Core feature

Ans. Pervasive pattern of detachment from social relationships. If two features, the second would be phlegmatic.

Q: Medications for Schizoid P.D.

Q. Which meds?

Ans: Meds for Schizoid

Ans. Sadock and Sadock list small doses of antipsychotics, antidepressants, and psychostimulents. Signs might help one make a choice, consider antipsychotic as having some empirical support [Tasman and Mohr].

Q: Schizotypal & schizoid disorders.

- Q. What do these two disorders share?

Ans: Schizotypal & Schizoid disorders share.

- 1. Social isolation
- 2. Restricted affectivity

- DSM-IV says that paranoid disorder also shares 1. and 2. supra.

Q. How are schizoid and schizotypal different?

Ans. How are schizoid and schizotypal different.

Schizotypal p.d. has cognitive and perceptual distortions that schizoid p.d. lacks.

Q. How is schizotypal p.d. different from paranoid p.d.?

Ans. How is schizotypal p.d. different from paranoid p.d.

- Schizotypal lacks suspiciousness and paranoid ideation.

Q: Schizoid disorder - treatment

- Q. Treatment?

Ans: Treatment of Schizoid disorder - 1

- Difficult given that the signs of the disorder are not ego-dystonic, but can try:
- 1. Supportive psychotherapy
- 2. Group therapy
- 3. No controlled studies on meds

[See next screen]

Ans. Treatment of schizoid p.d. - 2

Psychotherapy should be business-like, NOT emotional or intimate.

Q: Borderline - suicide

- Q. What percentage of borderline pts suicide?

Ans: Borderline - suicide

10% [More recent studies suggest 5%. Hopefully the exam will not ask we choosde between 5 and 10%]

Q: Borderline - prognosis

- Q. Prognosis of pts in treatment after two years? After 6 years?

Ans: Borderline - prognosis

- After two years, 44% still met criteria for borderline
- After six years, 26% still met criteria for borderline
- {most of these pts got meds and supportive psychodynamic psychotherapy}

- [Zanarini, AJP, 2003, 160:274-283.]

Borderline – brief hospitalization

- Q. Indications for brief hospitalization?

Ans: Borderline – brief hospitalization

- 1. imminent danger to others or self.
- 2. psychosis that seems to be directing untoward behavior
- 3. unresponsive in partial setting.

Q. Borderline – indications for prolonged hospitalization

- Q. What are the indications for prolonged hospitalization?

Ans. Borderline – indications for prolonged hospitalization

- 1. Persistent danger to others or self despite brief hospitalization.
- 2. Co-occurring disorder that represents a potential threat to life.
- 3. Unresponsive to partial AND
  - Persistent suicidal
  - Persistent self-destructive
  - Severely dysfunctional

Q. Borderline – indications for partial hospitalization

- Q. What are indications for partial hospitalization?

Ans. Borderline – indications for partial hospitalization

- 1. Can’t be evaluated adequately because of complexities as an outpt.
- 2. Can’t be managed adequately as to dangerousness or function as an outpt.

Q. Borderline – therapy contract?

- Q. List six subjects to resolve in a contract with the pt.

Ans. Borderline – initial contract

- 1. goals of treatment
- 2. role of both pt and therapist to achieve goals
- 3. sessions: how long and how often
- 4. how crises will be handled
- 5. clarification of therapists outside-session availability [no right answer to availability – just needs to be understood]
- 6. fee and payment schedule

Q. Borderline – efficacious psychotherapies

- Q. What psychotherapies have been established as useful in controlled studies?

Ans.Borderline – efficacious psychotherapies

- DBT [dialectical behavioral therapy]
- Psychoanalytic focusing on mentalization [not sure how question will be worded, but this controlled study was a partial program headed by Bateman].
- Supportive psychotherapy

[DBT's edge in comparison to other psychotherapies is with the parasuicidal signs.]

Q. Borderline – characteristics of successful psychotherapies?

- Q. What are characteristics of successful psychotherapies?

Ans. Borderline – characteristics of successful psychotherapies

Practice guideline lists three:

- 1. weekly meetings between pt and therapist
- 2. one or more group therapies
- 3. meetings of therapists for cross-consultation

Q. Borderline – focus of psychotherapies

- Q. What are seven common foci of psychotherapy with borderline?

Ans. Borderline – foci of psychotherapies -1

Ans. [the following somewhat overlap]

- 1. first issue is often suicidality
- 2. validating pts suffering
- 3. helping pt take responsibility for his/her actions.
- 4. managing feelings in both pt and therapist
- 5. [see next slide]

Ans. Borderline – foci of psychotherapies - 2

- 5. replacing reflections for impulsive actions
- 6. decrease splitting [pure DBT therapists, however, don’t like the concept of “splitting”]
- 7. setting limits on self-destructive behaviors

Q. Borderline – length of treatment

- Q. Recommended length of treatment?

Ans. Borderline – length of treatment

At least a year.

Q. Borderline - meds

- Q. Meds are not prescribed disorder-wide, instead are symptom clustered. What are the three clusters?

Ans. Borderline - meds

Three clusters:

- 1. affective dysregulation
- 2. impulse-control dysregulation
- 3. cognitive-perceptual dysregulation

Q. Borderline – meds for affective dysregulation

- Q. What meds for affective dysregulation? Say something about other options if the first is inadequate.

Ans. Borderline – meds for affective dysregulation

- A.
- 1. First choice, SSRIs or venlafaxine
- 2. If anxiety is still prominent with an SSRI, consider adding a benzodiazepine.
- 3. If affective dysregulation remains severe, considering adding low dose antipsychotic.
- 4. In the face of failure of above, consider a mood stabilizer.

Q. Borderline – meds for impulse-behavior dysregulation

- Q. What meds for impulse-behavior dysregulation?

Ans. Borderline – meds for impulse-behavioral dysregulation

- 1. SSRI.
- 2. If SSRIs are only partially successful, useful adjuncts include Li, valproate, and carbamazepine
- 3. If above fails, consider MAOIs.
- 4. Low dose atypical antipsychotics may be a good adjunct.

Q. Borderline – meds for cognitive-perceptual dysregulation

- Q. What meds for cognitive-perceptual dysregulation?

Ans. Borderline – meds for cognitive-perceptual dysregulation

First try low dose antipsychotics. If that fails, increase dose.

Q. Borderline – meds for “cutters”

- Q. What meds for cutters?

Ans. Borderline – meds for cutters

Same as for impulse-behavioral dysregulation mentioned supra. Also naltrexone is used.

Q. Borderline – treating "breakthroughs"

- Q. You have a pt on SSRI and in psychotherapy, doing OK for five months, then has return of signs and symptoms at severe level when her cat dies. Change meds?

Ans. Borderline – meds for “breakthroughs”

- Practice Guidelines suggest not blocking feelings in response to major life stresses, so maybe continue as before – not sure.

Q. Borderline – after 6 months and no better?

- Q. You are in solo practice and pt has not improved after 6 months despite your medicating and psychotherapy that has worked with other similar pts. What to do?

Ans. Borderline – after 6 months and no better

Practice Guidelines suggests you get a consultation, if not at 6 months, at least at 12 months.

Q. Borderline – managing splitting

- Q. How best to manage splitting.

Ans. Borderline – managing splitting

If therapists integrate their concepts and approaches with a pt, it helps the pt integrate her/his conceptualization and approaches.

Q. Borderline – family therapy

- Q. Role of family therapy?

Ans. Borderline – family therapy

Psychoeducation of the family can be helpful and family therapy sometimes can be a helpful addition. Never solo treatment, however.

Q. Borderline – couple therapy

- Q. Role of couple therapy?

Ans. Borderline – couple therapy

May be helpful, but not as solo treatment.

Q. Defense Mechanism Obsessive Compulsive P.D.

Q. What defense mechanism used in obsessive compulsive personality disorder?

Ans. Defense Mechanism Obsessive Compulsive P.D.

Ans. Isolation

Q. Defense Mechanism Histrionic P.D.

Q. What defense mechanisms are used in people with histrionic personality disorder

Ans. Defense Mechanism Histrionic P.D.

Ans.

Repression and disassociation

Q. Defense Mechanism Borderline P.D.

Q. What defense mechanism is used by people with borderline P.D.?

Ans. Defense Mechanism Borderline P.D.

Ans. Projective identification.

Q. Relatives of Pts with Somatization Disorders - 1

Q. Relatives of patients with somatization disorders tend to have which P.D.?

Ans. Relatives of Pts with Somatization Disorders

Antisocial P.D.

Q. Paranoid P.D. Defense Mechanism

Q. Which defense mechanism do pts with paranoid P.D. use?

Ans. Paranoid P.D.
Defense Mechanism

Ans. Projection

Q. Schizoid Disorder - dx

- Q. DSM-IV criteria for Schizoid Disorder? Four or more of what seven signs?

Ans. Schizoid Disorder - dx

Four or more:

- 1. Doesn’t desire close relationships.
- 2. Prefers solitary activities.
- 3. Little interest in sexual intercourse.
- 4. Takes pleasure in few, if any activities.
- 5. Lacks close friends.
- 6. Indifferent to criticism or praise
- 7. Emotionally detached.

Q. Therapists Get Angry. Defense Mechanism

Q. Patient's irritating style gets care givers angry. What defense mechanism is the pt using?

Ans. Therapists Gets Angry. Defense Mechanism

Ans. Projective identification

Q. From a genetic perspective, Antisocial P.D.

Antisocial p.d. is associated with what other DSM IV/5 dx?

Ans. From a genetic perspective, antisocial p.d. associated with . .

Alcohol use disorder

Q. From a genetic perspective, depression is associated with?

From a genetic perspective, depression is associated with which p.d.?

Ans. From a genetic perspective, depression

Borderline personality disorder

Q. From a genetic perspective, borderline's relatives

Patients witn borderline p.d. relatives have which disorders?

Ans. From a genetic perspective, borderline's relatives have . .

Mood disorders

Q. Genetically, histrionic disorder

Which disorder is found in the relatives of patients with histrionic disorder?

Ans. Genetically, histrionic p.d

Somatization disorder

Q. Saccadic eye movements

Characteristics of patients with saccadic eye movements?

Ans. Saccadic eye movements

"Schizophrenia" is probable answer [Sadock and Sadock], but if that is not a choice, one or the following may be correct:

Schizotypal p.d.

Introverted

Low self-esteem

Withdrawn

Q. Raising Serotonin levels

What “personality” changes are seen by increasing the serotonin levels?

Ans. Raising serotonin levels

Increased sense of well being.

Decreased depression, impulsivity and rumination.

Q. Increased slow wave

Increased slow wave on EEG associated with which p.d.?

Ans. Increased slow wave

Antisocial and borderline.

Q. Defense mechanism used in schizoid p.d.

Ans. Defense mechanism used in schizoid p.d.

withdrawal

Q. Schizoid - important

What is important to realize when treating people with schizoid p.d.?

Ans. Schizoid - important

Therapist should respect the patient’s fear of closeness and respect eccentric ways.

Q. Dealing with dissociation

How should the therapist deal with dissociation and denial?

Ans. Dealing with dissociation

In addition to firm and calm, consider using displacement to increase the patient's willingness to look at issues.

Q. Approach to treating isolation

Ans. Approach to treating isolation

[Often have dx of obsessive-compulsive p.d.]

Often, patients respond well to precise, systemic, and rational explanations. When possible, allow patients to control their own care.

Q. Approach to treating projection

Ans. Approach to treating projection

Can use counter-projection. Therapist does not dispute patient's complaints and does not reinforce them. Agree that patient's perception is possible and can talk about real motives and feelings, misattributed to someone else.

Q. Addressing splitting

Ans. Addressing splitting on hospital wards

After staff discussions that unite the staff, then gently confront patient that no one is all good or all bad.

Q. Describe projective identification

Ans. Describe projective identification

1. An aspect of oneself is projected onto someone else
2. Then an effort to coerce the other person into identifying with what has been projected.
3. If “2.” is successful, then the projector and recipient feel a sense of oneness.

Q. Treatment of Schizotypal?

Ans. Treatment of schizotypal

Low doses of antipsychotics.

Q. Treatment of Antisocial P.D.?

Ans. Treatment of Antisocial P.D.

Rather than attempt to develop a sense of conscience in these people, therapy should be focused on themes to avoid past mistakes.

Q. Treatment of Histrionic P.D

Ans. Treatment of Histrionic P.D.

A] Psychotherapy directed at:

1] counter diffuse style with structure and detail.

2] practical, immediate problems with daily life.

B] Use anti-depressants to address intense affectivity

Q. Antisocial and Histrionic

How do people with these two conditions relate to others?

Ans. Antisocial and Histrionic

Both tend to dominate, humiliate, and manipulate others.

Q. Treatment of Narcissistic P.D.?

Ans. Treatment of Narcissistic P.D.

- Without a lot of enthusiasm by authors, CBT and group therapy are mentioned.
- There is no medication approach.

Q. Treatment of Avoidant P.D.?

Ans. Treatment of Avoidant P.D.

1] social skills training

2] systemic desensitization

3] graded hierarchy of in vivo exposure

Q. Treatment of Dependent P.D.?

Ans. Treatment of Dependent P.D.

No empirical-based, but following may help:

1] CBT

2] Group therapy

Q. Treatment of Obsessive-Compulsive P.D.?

Ans. Treatment of Obsessive-compulsive P.D.

- CBT that addresses irrationality of excessive traits